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ON THE TREATMENT OF COLDS*

M. A. LISCHKOFF, M.D.,
Pensacola, Fla.

One must be impressed with the lack of progress and the great number of remedies offered for the treatment of colds. Quite frequently we read of experiments performed in different places, almost at the same time, and each arriving at different conclusions. It is then apparent that we lack some vital concept or our journals would not be filled with so many well-meaning advertisements of diversified offerings. For that reason it should be the duty of the profession to attempt to arrive at a better understanding of the pathology, and until we do we should consider colds a phenomena complex and treat them as such.

We cannot accept the bacteriological cause of colds, but must admit that infection plays a definite part. We can even go farther and recommend the use of both stock and autogenous vaccines both as a prophylactic and curative. In many instances, vaccines have given definite cures that had yielded to no other remedy. Climate and seasons have their enormous toll, but that alone does not prove it a cause. It must, however, be considerd in outlining therapeusis. Many feel like local pathology in the nose or throat is a very important factor, yet we see many tonsillectomized or other post-operative patients returning for treatment or at least only slightly benefited.

The most logical treatment, even though empirical, would then seem to be general and local as well as etiological. The former would include everything systemic from tonics to eliminants; local would be aimed more at relief of distress, drainage, etc., and the treatment with reference to etiology would be more prophylactic.

Different stages of a cold require different remedies, but there are a few fundamentals that we can all agree upon. A day in bed is one of the most useful yet impractical suggestions one can offer. Yet our adult males do not consider it sufficiently important to warrant a day from business and will only occasionally allow such a severe remedy to be used. Those of us who recommend a day in bed and a dose of castor oil have often been gratified to find our patients materially improved and all of us look upon that as an excellent method. But catharsis is only of relative importance and purges only help those subject to constipation.

With our heat regulating mechanism, sugar, fat and calcium metabolism affected, it is no wonder that a cold will often respond to one remedy this time and not the next. Probably one important factor is the apparent indifference which patients apply for treatment, because most adults only reach us after their friends, druggists and home remedies have failed.

It would seem that we should attempt to agree on some rational procedure. Why should some prescribe atropin to combat nature when she is making every effort to eliminate by stimulating secretions, while others use one of the common older treatments consisting of hot baths to produce diaphoresis? In fact I know of no procedure that has given me the quick relief of hot or Turkish baths, and I feel like hot baths, cleansing of sinuses with negative pressure followed by nasal astringents, vapors, etc., will at least make my patients feel better. To that we may add alkalinization, aspirin or other salicylates and occasionally urotropin. These increase relief tremendously. After that it resolves itself to investigating the etiological factors, such as clearing up nasal pathology, reducing undue exposure, increasing the general resistance with tonics, cold baths, exercise and sunshine.

It has been my recent observation that zinc ionization has materally aided some few, but having only used this remedy for the past few months I can only throw this suggestion out with the hope that you give it a trial. Those patients whose sinuses are draining profusely seem to be most benefited, but the extension of this to other drugs may lead us to happy findings. I have used Dakin and Silver salts, but with a limited number of cases, hence I cannot report anything conclusive. In a paper now being prepared I will report these cases in detail.

It does occur to me that cod-liver oil is still a useful remedy and I prescribe it especially for children. Whether the fat vitamins or increased

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calories are responsible for the good I cannot say, but all of us have seen good results obtained and consider it useful. It would seem like quinine is losing its usefulness with the disappearing of malaria. For a while a remedy gives excellent results, then reports seem to conflict and finally it is discarded. Can it be that we accustom ourselves to this remedy or does the virulence of the organism vary? Or is there still another cause? It is an established fact that continued use of certain drugs reduce their efficiency and it may be that in the treatment of colds we have no exception.

Only a short while ago we were startled at results claimed for chlorine, but now our enthusiasm is waning and the best reports are those salvaged by the manufacturer. In my personal experience extending over a period of eight months I can only point to a small number of cases positively benefited by the use of chlorine, but believe that further experience will increase our knowledge so as to help us select the cases chlorine will aid. The only cases in my own practice that were really benefited were the ones treated very early. I would not want to give up the use of chlorine as yet and hope future use will bring out some valuable points not yet generally known.

If I have given you nothing new I will have at least reminded you of existing conditions as they appear to me so that future investigation will bring us a better understanding of this condition. With such a widespread prevalence and tremendous economic loss, colds and their treatment should be better understood.

DISCUSSION

Dr. H. Marshal Taylor, Jacksonville:

Etiology and treatment of the common cold is now receiving more attention perhaps than at any time in the history of medicine. At the last meetings of the American Laryngological, Rhinological and Otological Society and the Ear, Nose and Throat Section of the Southern Medical Association and the American Medical Association, symposiums on this subject were on the program. As yet there is a fertile soil for further investigation of this important subject, both as to the etiology and treatment. There is some question even with the tremendous development in medicine along bacteriologic and immunologic lines whether we really know more about common colds than did our forefathers.

Dr. Lischkoff has well said, "We can not lay down one treatment for every case." It is important that the general practitioner as well as the rhinologist should in every case recognize the probability of an infection of the paranasal sinuses. The virtue of the chlorine treatment has yet to be proven. More physicians at this time seem to condemn it than recommend it. It seems that the manufacturers of the chlorine apparatus are its most ardent supporters. When you read of the violent attacks of asthma precipitated by its administration and some few deaths attributed to its use, it is easy to understand why the chlorine treatment has been condemned by the New York State Board of Health.

Dr. B. W. Lowry, Tampa:

I have always been very much interested in the subject of colds. Justly I think that all colds eventually become infectious. I don't think at first that there is a real infection, but after the cold has been in progress for twenty-four hours, I believe that the germs are there causing the symptoms. Therefore, with inflammation of the nasal passages there is congestion and an outpour of secretion.

Now, the logical way to look at this is to reduce the stage of congestion to the stage of relaxation, and we have several methods of doing this: The first method is by free catharsis, that old-time remedy which I think still holds true. The second is by sweating the patient. This certainly reduces the congestion in the head. The third is by artificially shrinking the mucous membrane of the nasal passages by the use of adrenalin, cocain, etc. This merely dilates the nasal passage, it does not cure. It gives air and relieves the patient, but does not cure the case. Now, if you are going to cure the patient you have got to introduce some method of sterilizing the nasal mucosa. And in my cases the use of vaccines has been absolutely useless. I don't recall a single case where I can honestly say that I have cured a case of cold. I may have increased that patient's immunity to further colds, but I don't believe that I have ever cured a case by the use of vaccine, either autogenous or stock.

I have had the opportunity of using chlorine gas within the last year on one hundred selected patients, and I would like to report my results here. I use the Wallace inhalator. I have no confidence in the gassing chamber. I believe that you can insure the proper concentration over a period of one hour, and if you are to get

results you must have the same concentration at the end of sixty minutes that you had when you started. The only way you can do this is by the Wallace inhalator. The proper concentration should be point 105 of chlorine per leader of air. If this is taken over a period of one hour in cases of acute coryza, acute bronchitis, and acute laryngitis after the passages have been previously shrunken by adrenalin, you will get results. In my series of cases I can honestly say that between 40 and 45% of the acute coryzas were either cured of the symptoms or relieved within twelve hours after the first treatment. They came back on consecutive days, and the greater percentage were cured.

Now, I don't know whether this is due to the sterilizing action of chlorine on the germs, or whether it is the irritant action on the mucosa causing increased resistance, or whether it is due to the increased flow of serum which mechanically washes out the germs from the nasal passages, but I have gotten results with chlorine gas by using this particular method. I have used the air chamber, but not so much, for I have no confidence in anything other than the inhalator.

I do think that the use of mercurochrome and silver salts of course is good, but I don't believe that they compare with chlorine gas in treating acute head colds.

Dr. M. A. Lischkoff, Pensacola (concluding):

I have very little to add. But I do think that what Dr. Lowry has said about paranasal sinuses is worth considering. In every case of cold we do have a paranasal infection, but I do not know whether we are going to treat our paranasal sinuses in every case of cold.

I am sorry to disagree with Dr. Lowry, for his experience and mine has been so different in the use of chlorine. I have constructed a small chlorine chamber and carried out the chlorine inhalations as per instructions with apparently the correct dilution. I have not selected my cases, however, but in many cases have shrunk up the nasal mucosa, then used the suction pump, and then exposed them to chlorine; but I don't think that they were a bit more comfortable or got well any quicker than those that did not have the chlorine treatment.

MODERN METHODS OF DIAGNOSIS AND TREATMENT OF URETERAL CALCULUS*

EUGENE S. GILMER, M.D.,

Tampa, Fla.

The diagnosis and treatment of ureteral calculus has been discussed by medical men so long that the present consideration deals more with the advances which the specialist has been able to make. The advent of the cystoscope and the X-ray has revolutionized the diagnosis of stone and the treatment has been immeasurably improved. No branch of medicine or surgery has reached a higher point of diagnostic acumen than has urology with the recent refinements in instrumentation and diagnostic methods in the hands of trained men. Kretschmer divided the modern diagnosis and treatment of ureteral calculus into three more or less arbitrary periods. The first began when the use of rœntgen rays was introduced as a diagnostic measure, when many stones were found and wrongly interpreted. The second began with the introduction of the shadowgraph catheter, and this was followed by the stereoscopic rœntgenograms. To this I would add pyelography which is the most important aid in the diagnosis.

A complete physical and urological examination should be made in every case of suspected calculus, and the following questions should be considered:

First. Whether the trouble is in the ureter or elsewhere?

Second. If the condition is in the ureter, is it a calculus?

Third. If it is a calculus, how many are there, in what part of the ureter are they located, what are their size and shape, and are there stones on the opposite side?

Fourth. What is the condition of the kidney on the corresponding side as well as on the opposite side?

Fifth. What is the condition of the ureter containing the stone?

Sixth. What is the general condition of the patient?

A careful personal and family history should be taken, repeated examinations of the urine, X-ray study of the urinary tract, cystoscopy and

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ureteral catheterization, and pyeloureterography.

The family history should include the occurrence of malignancy, tuberculosis or calculi. In the personal history, the former residence, social status, personal habits, present and past occupations, venereal history, past and present symptoms and signs, such as renal colic with the passage of stone, hemoturia, pyuria, chills and fever, pains in the back, urinary symptoms, and unexplained or vague abdominal pain or tenderness are important. In the physical examination special attention should be paid to the blood count, blood chemistry, kidney function, and palpation of the abdomen for kidney, ureteral and abdominal enlargements and tenderness.

Examination of the urine may show blood, bacteria or urinary crystals, any or all of which may suggest the presence of a calculus. A few blood or pus cells may be of little importance, since they may be found in so many other conditions; but when taken in connection with other clinical data, may be valuable signs. When found, they at least suggest a careful urological study of the patient. If pus and bacteria are found in the known presence of stone, this finding may prove the deciding factor in the plan of treatment.

By X-ray examination we may be able to determine the presence or absence of stone; and if present, whether single or multiple, unilateral or bilateral, the exact location, size, shape and position. By repeated study we may also determine whether the stone is impacted or whether it is making progress along the ureter and will probably be expelled spontaneously.

It would seem that, with modern methods of X-ray diagnosis, few stones would pass undetected with an expert roentgenologist, who is given sufficient opportunity for repeated study. However, the fact remains that quite a few stones are not recognized by X-ray examination. Braasch and Moore state that it is doubtful if an accurate diagnosis of ureteral calculus can be made from a roentgenographic examination alone.

Rowland reports that in twenty cases he had removed stones from the ureter where the radiologic reports were negative. He does not attribute this to poor radiography, but thinks it is due to small or translucent stones or to the obesity of the patient. Failure to recognize stone may also be due to its relation to bone. Cabot and Dodd suggested that, in cases where the suspected calculus lies over the sacroiliac joint, by taking a radiogram with the tube placed over the umbilicus and focused obliquely down into the pelvis, we may detect a calculus obscured by this bone. Cabot found that 6% of 127 cases were persistantly negative to X-ray, but he believes that, as a rule the rœntgen rays in competent hands at the time he made his report failed to detect stone in 10 to 15% of the cases. Geraghty and Hinman found that X-ray failed to show the presence of stone in 15% of their cases, and in Kretschmer's series X-ray failed to show the stone in a little less than 11%.

By cystoscopy and ureteral catheterization, we may study the general condition of the bladder and the ureteral orifices. If a stone is situated in the lower part of the ureter near the bladder, there may be either a discoloration of the vesical mucosa around the orifice, bulging of the bladder wall over the stone, œdema of the ureteral orifice, and sometimes the calculus may be seen protruding from the orifice. Some authorities state that a wide open, paralyzed sphincter of the orifice is diagnostic of stone. Ureteral catheterization will allow study of the kidney on the corresponding side as well as on the opposite side and an index may be obtained as to their condition. We may determine whether there is an obstruction in the ureter and its exact location. Catheterized specimens of urine may be obtained from each kidney and examined. The wax-tipped catheter may be passed and examined for scratch marks in doubtful cases. Lastly, opaque solutions may be injected through the catheter, pyeloureterograms may be made and a clear outline of the ureter and calyces obtained; and a calculus that has failed to show in previous radiograms may be coated over by the opaque fluid and will show readily by radiography. It is better in this case to allow a few hours to lapse between the time of injection of the opaque solution and the radiography to give the fluid time to drain off and leave the calculus coated. Negative shadows may be demonstrated by this means that would not show any other way.

Several cases have been reported of palpation of ureteral calculi by vaginal and rectal examination, but this is seldom possible and is of little value in comparison to other means of diagnosis. Exploratory operations should never be performed as a diagnostic measure.

Ureteral calculus must be differentiated clinically from ureteral stricture and ureteral kinks. By radiography, ureteral calculi may be differentiated from prostatic calculi, bladder concretions, atheromatous patches on the arterial wall, exostoses, foreign bodies and concretions in the intestines, surface moles, calcified lmph glands, gall stones and phleboliths; all of these can practically always be differentiated by use of the cystoscope, shadowgraph catheter, roentgenography and stereoscopy.

Treatment of ureteral calculus consists of expectant, conservative and radical. We can offer no rational or scientific prophylactic measures until we can definitely determine the etiology of urinary stone.

Expectant treatment: Various and sundry drugs and mineral waters have been recommended for the disintegration of stone, but none has proved of any real value. The only report in the literature that I have been able to find is by Crowell, who succeeded in accomplishing the disintegrating of a cystine calculus by a low protein diet, alkalinization of the urine and lavage of mercurochrome 220. Israel recommends the daily administration for one week of two quarts of mineral water and three ounces of glycerine.

Conservative treatment: There seems to be a divergence of opinion regarding the operative treatment of this condition. European surgeons seem more inclined to open operation, while the tendency of America is toward conservatism.

Most autorities agree that a stone less than one cm. in diameter should be expected to pass spontaneously, while others claim that in the absence of infection and other unfavorable circumstances much larger ones should be given the opportunity to pass. I recently observed a case in which the stone measured one and one-half cm. in diameter and traveled from the kidney pelvis into the bladder with scarcely any discomfort to the patient and no notable damage. The procedures in a given case must, of course, be left to the skill and judgment of the attending surgeon. Braasch thinks that the majority of stones will probably pass within two or three months following the first symptoms, and that in the absence of complications we should wait for from three to six months. Judd found that, in 400 cases, 12% passed unaided and in 16 cases Kahle found that 33% passed spontaneously.

It is unsafe to leave a ureteral calculus indefinitely. If it is not making sufficient progress in its descent toward the bladder; if there is evidence of infection, urinary obstruction, or interference with the kidney function; if there is a calculus in the opposite ureter, then some form of active interference must be instituted to either assist the stone in passing or to remove it. It is evident that ureteral calculi should be treated more systematically and promptly than renal calculi. I recently found it necessary to remove a very small migratory calculus that was causing intermittent obstruction and serious damage to an infected kidney.

The question arises whether our procedure shall consist of cystoscopic and ureteral munipulations as the conservative treatment or open operation for the removal of the stone. If the stone is not too large and not in the upper ureter, if it is not a case of multiple or bilateral calculi, if it is not impacted so as to prevent the passage of catheter or bougie, and if instrumentation is tolerated, we should adopt the conservative measures, unless contra-indications arise, until we feel sure our efforts by this method will be unsuccessful. Its advantages are obvious. Aside from relieving the added inconvenience necessary to open operation it gives the patient immediate relief by draining the kidney and relieving back pressure, thereby preserving its integrity, and assists the stone in its passage along the ureter by either changing its position or dilating the ureter so as to give it easier passage. Many authorities agree that we should not wait for ureteral stones to pass spontaneously, but that intraureteral manipulation should be begun early. Buerger believes that it is advisable in almost every case, after the stone has found lodgment, and in every case of obstruction, unless the stone is passed within twenty-four to seventy-two hours. He has also observed that the greater the distance between the stone and the kidney the less damage there is likely to be to the kidney.

Intraureteral manipulations may consist of simple ureteral catheterization in which one or more catheters are introduced past the calculus and left for varying periods of time. This is repeated at intervals until the stone passes or the ureter is dilated to 12 or 14 F. If two or more catheters are introduced they should be crossed within the ureter and removed simultaneously, when they may drag the stone out with them, or at least for some distance along the

ureter. A recent authority recommends the passage of large, tunneled metal bougies. Some surgeons think that oil or glycerine injected through the catheter assist in the expulsion of stone. Others use papaverine or other similar agent to relieve ureteral spasm. Dilation is sometimes accomplished by means of the Garceau catheter or the Bransford Lewis metal dilator. If the stone is in the intramural portion of the ureter, fulgeration is sometimes more effective. If it can be seen protruding from the orifice it may be grasped by forceps and withdrawn. In cases of intramural impaction, incision of the upper lip of the orifice may allow expulsion of the calculus.

Crowell and Thompson believe that nearly all recently impacted ureteral calculi can be removed by intraureteral manipulation and report seventy-eight consecutive cases, seventy-six of which were removed by this means. The writer has been successful in removing the ureteral calculus by this means in ten consecutive cases in the past few months, one of which was an impacted calculus which required three efforts to introduce a bougie past the obstruction.

Radical treatment: Calculi that do not pass spontaneously, or after repeated unsuccessful attempts at removal by intraureteral manipulations, should be removed before too much damage is done to the kidney. Encysted calculi or those too large to pass require operative removal. If there are evidences of urinary suppression, of infection of the kidney back of the stone, or repeated "colic"; if there is evidence of serious impairment of renal function; if there is a hydronephrosis not sufficiently relieved by ureteral catheterization, open operation should be performed unless cystoscopic manipulations are immediately successful. Cases of intolerance to cystoscopic manipulations, or where these manipulations tend to light up an old infection, should be operated on. We should not temporize in cases of bilateral calculi and, in these cases, the one giving the greater amount of trouble should be removed first. If there is a calculus in the kidney on one side and in the ureter on the other, the one in the ureter should be removed first. In cases of calculous anuria, nephrostomy should be performed first and the calculus removed later.

The type of operation to be employed depends upon its location in the ureter. If it lies in the upper third, the incision should be the same as for exposure of the kidney; if in the middle or lower third, an exaggerated McBurney or a Gibson incision will give proper exposure. If the calculus is movable, a longitudinal incision should be made in the ureter just above its location and the stone displaced upwards since there is danger of opening through ulcerated mucous membrane in making the incision over the stone. Unless the incision in the ureter is of considerable length, it is probably better not to suture the ureter, but a small rubber tissue drain should be left down to the ureteral incision as long as there is any ureteral drainage.

In closing, let me warn against any operative procedure without an immediate X-ray examination, as much time may be lost trying to find a calculus that has changed its position since it was last located by the X-ray.

DISCUSSION

Dr. Rob't B. McIver, Jacksonville:

The question of stone in the ureter is of more importance than we are apt to assign to it.

A decade ago many general surgeons of considerable ability operated for stone upon making the diagnosis; this was considered good practice in many localities as recently as five years ago. At present it is very definitely established that only a small percentage of ureteral calculi require an open operation. In our experience 90% of the calculi that do not pass spontaneously can be assisted into the bladder by intraureteral manipulation.

Dr. Gilmer has been able to cover the subject in considerable detail in fifteen minutes. I have nothing to add to his paper, but will demonstrate a series of lantern slides which illustrate some of the many problems presented by ureteral calculi.

(Slides)

THE PHYSICIAN AND THE HEALTH OFFICER

F. A. Brink, M.D.,

Director, Bureau of Communicable Diseases, State Board of Health.

Practically all who undertake the study of medicine, graduate from a reputable college and secure a license to practice the healing art, are of good moral character, interested in the welfare of the human race at large and have more than the average amount of interest and pride in the community where they live and work. It

is rare, indeed, to find a practicing physician who would not devote his best effort to the prevention of unnecessary sickness. Although nearly all doctors must depend on the income from their practice for a livelihood, it is only under exceptional circumstances that one becomes mercenary or resorts to questionable methods to increase his income. The crooked doctor is quickly recognized by other members of the profession, excluded from medical societies and soon known by all as a charlatan. He has both the contempt and pity of his confreres and he enjoys neither prosperity or the friendship of his associates. All this is preliminary to a word of recognition and appreciation from a health official to the ethical practitioner who, when approached in the right spirit and given the consideration he merits, never fails to give his moral support, time, skill and even financial support to any scheme that will improve the health of the people he serves.

There is no other profession or class of people who will, for the benefit of their community, put forth effort that might be expected to reduce their income. But, strangely enough, those practitioners who are most ready to work for the promotion of the public health are the most successful financially. Whether this is due to the ministrations of a kind Providence or merely the natural sequence of cause and effort, may be left to conjecture, but it may be noted in passing that the family or community that enjoys the best health is also the most prosperous and best able to meet its financial obligations; conversely, the sickly family or community has little but poverty to share with the doctor.

Frankly, it must be admitted that, aside from a feeling of gratitude to the profession, the writing of this article is prompted by a wish to foster and encourage that spirit of community helpfulness on the part of the physician which, after all, benefits him and his family as much as anyone.

Public health workers in the Middle West tell of a fear that is growing among the doctors that state medicine may deprive them of a livelihood. Ill-founded as this fear may seem, it must be recognized and allayed if the best interests of the people and the profession are to be conserved. To the writer there seems little danger that the practitioner will be replaced by men employed by the state, and the doctors of Florida have expressed no anxiety about it. Certainly the state is not likely to offer the public anything in the way of disease prevention or cure that is already provided by local physicians. There will always be enough for the official health worker to do without invading the province of the practicing physician. The health worker will have to keep pointing out to the public the physical defects of children and advise correction by the family physician or specialist, he must keep insisting on the prevention and cure of hookworm disease, malaria, diphtheria, etc., there will be communicable disease patients to isolate, group examinations to make, immunization and laboratory tests that can best be done by full time employees of the state, but the time will never come when the community can dispense with such individual services as the family doctor alone can render, and never will the family doctor fail to serve the community in time of need as he has always done.

The doctor of medicine who devotes all his time to public health work and receives a stipulated salary is still a doctor of medicine. He should extend and receive the same professional courtesies that are recognized by men in practice. He cannot, however, do all the health work that must be done. One of his chief activities is to stimulate the interest of the people in doing health work for themselves and instructing them in the manner of doing it. In this it is essential that he have the backing of the local doctors, for people will heed advice coming from both better than if it came from either alone. It is not true, as sometimes stated, that since we have paid health workers there is no longer need for the volunteer services of the practicing physician. The need is almost as great as ever and there is every reason to believe that the practicing physician will continue nobly to render those services.

THE LABORATORY AS AN AID IN DIAGNOSIS*

WALTER C. JONES, JR., M.D.,
Miami.

It shall not be the purpose of this paper to deal with the various techniques necessary to obtain the results sought, nor attempt in every case to explain the underlying principle, since these are so well undertaken in the various laboratory manuals of the current medical press. In as large a scope as time will permit, the reports of

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the laboratory will be discussed and conclusions try to be reached which will be of value to the general practitioner in his every-day rounds. In this connection, however, it will not be possible to discuss all the various clinical findings of each case, and conclusions stated will try to be those of the average cases and not the unusual ones.

In consideration of the *sputum,* much is of value to the clinician, but probably nothing more important than examination for the tubercle bacillus. A negative report does not necessarily mean that the patient is free from tuberculosis; for tubercle bacilli do not occur in the sputum until a secondary infection has occurred, and the resulting small cavity formation. Then, too, when the case is far enough advanced to have the bacilli present, if one examination fails to show them, continue daily examinations for at least three days and preferably using the 24-hour amount with the concentration technique. In this connection let it be clearly understood that you are doing your patients a criminal injustice if you wait until you find the bacilli to notify them that they have tuberculosis. In its incipiency by your clinical history and physical findings, together with your personal observation of the case, forewarn your patient of approaching danger and by all means don't wait for a positive report from the sputum. In an advanced case, apparently tubercular but with a negative sputum, the "court of last appeals" is the inoculation into the guinea pig—this is absolutely a reliable test if performed properly. The presence of *elastic fibers* in sputum means that lung tissue is being destroyed, and the most common causes of such destruction are tuberculosis and gangrene. *Curschman's Spirals* and *Charcot-Leyden Crystals* are most frequently seen in bronchial asthma.

In interpreting the sputum report, ask first is it negative or positive? If positive, then for tuberculosis the diagnosis is made; if negative but elastic fibers are present, it is suspicious, and request another examination and concentration technique; if still negative, continue for at least three successive examinations before abandoning a suspicious case. In all cases rely first upon the findings of the case and a common-sense clinical judgment, and then if the laboratory report helps in diagnosing the case, so much the better; but don't let the laboratory report be paramount. It has its place and is of inestimable value so often, yet it becomes mighty easy to rely on it and forget that most valuable of the practitioner's implements, clinical judgment.

A routine examination of the *urine* is a good habit to form and will save many a slip along the arduous pathway. The general medicine man cares not what may be the interesting features of a specimen so far as they concern the laboratory man, but his main thought in testing the urine is to find out if his patient possibly has some disease of the kidneys or genito-urinary tract.

The presence of sugar does not mean diabetes mellitus in every case—lactose in a nursing or pregnant woman may be the cause, or emotional strains, or excessive carbohydrate ingestion. Then, too, the absence of sugar in a single specimen does not rule out diabetes; some cases only excrete sugar at certain hours of the day and some, with a markedly increased blood sugar, may show no sugar in the urine. *These points* must be borne in mind when translating the urinary report of a suspicious diabetic—is the quantity increased; is the specific gravity increased, then what is the percentage of blood sugar?

Albumen present—what does that mean? No greater mistake can be made than to regard all cases of albuminuria as indicating kidney disease. Excessive muscular exertion, excessive eating or drinking, prolonged cold baths, and posture may be the cause of a transient albuminuria which will clear up when the cause is removed. Abnormally it may be present in anemia, purpura, and scurvy in small amounts because it is more diffusible in such cases; also in anemia or congestion of the kidneys themselves; and especially in organic diseases of the kidneys as the various types of nephritis, tuberculosis, tumors, and cloudy swelling due to toxin and drugs. It is in large quantities in all cases of nephritis except the chronic interstitial type where it is less marked.

Casts may be present in large numbers due to a temporary irritation or congestion — within themselves they do not imply organic disease of the kidney, but simply indicate the condition of the tubules in which they were formed. Hyalin casts are the least significant and in small numbers they follow ether anaesthesia, fever, exercise, congestion, and kidney irritation. Granular casts, fine and coarse, indicate that the process is a bit further advanced and that organic changes

are occurring in the tubules; the same is true of fatty casts, indicating that partial or complete disintegration of the renal epithelium is occurring. Waxy casts occur in advanced cases of nephritis, most commonly in amyloid disease of the kidney. There are other types and variations of cast, depending upon the degree of disease and combinations of types.

Pus corpuscles occur in very small numbers, normally. Their increase may be due to infection along any portion of the genito-urinary tract or within the kidney and its pelvis. With clinical symptoms of a pyelitis—one of the most common causes of temperature in children—failure to find many pus corpuscles at one examination does not rule out pyelitis; for the kidney flushes itself irregularly in some cases and one specimen may be clear and the next cloudy with pus.

Red corpuscles, too, may come from any portion of the genito-urinary tract—if bloody urine, use the 3-glass test and it may be possible to determine the site of origin. If the blood is chiefly in the first glass, it is probably urethral; if in the last, it is probably in the bladder. If the blood is uniformly mixed in all 3 glasses, it probably comes from the kidneys or ureter. Blood from the kidney is due to severe hyperemia, renal tuberculosis, malignancies, hemorrhagic disease, and renal calculi (in small amounts with pus corpuscles and crystals).

Indican is increased in intestinal trouble, hypochlorhydria, or decrease of flow of bile. It commonly bespeaks some intestinal putrefaction and is most marked in intestinal obstruction.

Specific gravity—average is 1.017 to 1.020, but it is low in chronic nephritis, diabetes insipidus, and nervous diseases, being high in acute nephritis and diabetes mellitus. A sudden fall of the specific gravity in any nephritic case, without a corresponding increase in the quantity of urine excreted, forebodes uremia. A very valuable simple test of renal efficiency is a test for fixation of specific gravity—have specimens collected every 2 hours during the day and put in separate containers, likewise collect as a whole the night specimen. Take specific gravity of each and measure the quantity excreted. Normally the urine will vary 12 or more points during the 24 hours. If there is a variation of less than 9 points and the quantity excreted at night exceeds that of the day, then you most likely are dealing with a case of chronic nephritis. Cabot is very emphatic in proclaiming this one of the most reliable tests for chronic nephritis—however, in reaching such a conclusion the clinical picture must not be lost sight of.

The phenolsulphonephthalein functional test is also of valuable assistance in arriving at a conclusion as to renal efficiency. Normally the first trace appears in 5-11 minutes, and during the first hour 40-60% is excreted and at the end of the second hour 60-85% of the quantity injected has been excreted. Variations of these amounts form the basis of conclusions as to the involvement of the functional capacity of the kidneys proper.

The presence of acetone bodies—diacetic acid, acetone, and Beta-oxybutyric acid—is due to abnormal katabolism. Acetone is sometimes present in fevers, nervous diseases, gastro-intestinal disturbances, lack of carbohydrates, and often in pernicious vomiting of pregnancy and eclampsia. In diabetes mellitus the presence of any is an indication of its severity. They can be diminished by the giving of liberal carbohydrates. The mildest form is acetone, then diacetic acid, and worst is Beta-oxybutyric acid.

In studying the *blood,* probably 90% of the information obtainable can be obtained by an estimation of the hemoglobin and a study of a stained smear. The normal quantity of *hemoglobin* is 14 grams per 100 c.c. of blood and read as 100% upon such a basis. It is *increased* in change from a lower to a higher altitude, heart disease with cyanosis, concentration of blood as in severe diarrhea of cholera and in "idiopathic polycythemia." There is a *decrease* in the anemias, malignancy, hemorrhages, hookworms, chlorosis and leukemias. The *color index* is obtained by dividing the percentage of hemoglobin by the percentage of red blood cells. It is normally 0.8-0.9, but is usually markedly decreased in chlorosis and the secondary anemias, while there is quite an increase in pernicious anemia—1.0 or more.

The *erythrocytes* normally are 4½ to 5½ million and show an increase in change from a lower to a higher altitude and markedly so in "idiopathic polycythemia." There is varied decrease in the anemias, and chorosis, but the most marked is found in pernicious anemia, where counts below 1 million are not uncommon. In this latter condition change in size, shape, and staining qualities is quite marked. Here also are

found nucleated red cells, but especially the megaloblasts.

The *leukocytes* vary normally from 5 to 10 thousand, being low in the poorly nourished, anemias, and aged; while they are high in the new-born, children, after the digestion of a meal, and after cold baths. A pathologic decrease of the leukocytes, or a *leukopenia* is seen in pernicious anemia, tuberculosis, typhoid fever, typhus fever, malaria, measles, mumps, dengue, influenza and scarlet fever. An abnormal increase or a *leukocytosis* is found in all inflammatory and suppurative diseases unless very slight or well walled off. The increase depends upon the severity of the infection and the resistance offered by the individual.

It has been said the percentage of polymorphonuclear leucocytes indicates the severity of the infection and that the total count is a guide as to the resistance offered. A gradually increasing leukocytosis indicates a spreading process, a percentage of polymorphonuclear-leukocytes of over 85% points towards pus formation. There is a moderate leukocytosis in malignant conditions, following hemorrhages, toxic conditions, and following the administration of tonics and stomachics. A *lymphocytic leukocytosis* is seen in pertussis, where the number may reach 18,000 with a marked predominance of small lymphocytes — rickets, scurvy, and hereditary syphilis likewise show a moderate lymphocytic leukocytosis. There is a relative increase in the *large mononuclear leukocytes and transitionals* (or "endothelial leukocytes" as they are sometimes classed) in typhoid fever, malaria, and early Hodgkins disease. An *eosinophilic-leukocytosis* (relative) occurs in cases of intestinal parasites, bronchial asthma, scarlet fever, skin diseases, and following tuberculin reactions and anaphylaxis.

Myelocytes in considerable numbers are diagnostic of myelogenous leukemia. In the anemia of malignant disease, when found, they suggest bone-marrow metastasis. *Myeloblasts* are the parent cells of the myelocytes and are found in large numbers in acute myelogenous leukemia and the late stages of chronic myelogenous leukemia—hence are of prognostic value.

In searching for malarial parasites the best time to take the blood is a few hours before the chill, when the parasites are well grown and before they rupture into the blood stream. Quinine causes the parasites to disappear from the peripheral blood and few or none may be found after its administration. When it is impossible to find the parasites, the presence of pigment granules within the leukocytes—especially the large mononuclears—may be taken as presumptive evidence of malaria. These are most numerous after a paroxysm. It is claimed a hypodermic injection of adrenalin Hydrochlorid (1: 1000 Mx) will cause the parasite to appear in the peripheral blood.

In studying *gastric contents* the test meal and time of removal has much to do with the results. From various experimentations it has been proven that the fractional removal of 5 c.c. every 15 minutes, and test of same separately, gives a far more accurate estimate of the gastric function. In some cases the acidity may rise rapidly and reach its maximum in 30 minutes and return to normal by the end of the one-hour period, and in other cases the maximum acidity may not be reached until after the one-hour period. If only the one-hour specimen is studied, clearly it can be seen that the actual condition of the stomach has not been found. With the Rehfuss fractional method in cases of *gastric ulcer*, the ascent of the acid is rapid and may reach its maximum before the hour or a little after. The high point of free acidity may be between 60 and 70 and the total acidity between 100 and 110. There is then a gradual decline as the stomach empties itself. In *duodenal ulcers* the ascent of the acid curve is gradual and proceeds to reach its maximum heighth when the stomach is emptying itself. In *gastric carcinoma* with obstruction, the free acid is either entirely absent or rises to a point between 10 and 15 after one hour; on the other hand, the total acidity may be normal or above normal. Reflex irritation due to gall-stones, appendicitis, etc., may influence the gastric curve markedly and give results simulating ulcer.

In the *feces* traces of occult blood are found in practically every case of gastric cancer and ulcer, also in malignancy of the intestines, and in presence of certain intestinal parasites. After a very heavy meat diet occasionally a positive test may be obtained. The presence of certain parasites, their ova, or segments is absolutely diagnostic of the respective conditions. In having a search made for the Endameba Hystolytica it is absolutely necessary that the specimen be fresh and kept warm until and during the examination.

In all suspicious throats a smear and culture should be made for the diphtheria bacillus. To

neglect such may mean an inexcusable mistake; for in diseases where positive assertions can be made and specific treatment given, to fail to avail oneself of the opportunities approaches criminal negligence. Cultures of various infections may assist greatly in diagnosis and treatment. A negative smear for gonococci in the male or female, but especially the latter, does not exclude the presence of the disease deep-seated. A positive smear in such cases is without a question diagnostic of the venereal condition.

In all suspicious lesions of the genitals, a dark-field examination for the Spirocheta Pallida is justifiable, and if the spirocheta are found, treatment should be instituted at once and not wait for a positive Wassermann, which may not appear before the second or third week and often as late as three months; by such delay the parasites multiply and become diffused throughout the lymph and blood paths, thus rendering cure less rapid and less sure. The ideal time for treatment of syphilis, therefore, is in the primary stage with a negative Wassermann. The Wassermann reaction as a rule becomes rapidly and strongly positive as the general manifestations of the disease develop; in late and especially in latent syphilis the reaction again grows weaker and in cases negative. Again it is to be emphasized that the case as a whole must be studied and not too much dependence placed upon the laboratory report except as it backs up the clinical findings. A negative blood Wassermann is no evidence of the absence of neurosyphilis; an examination of the spinal fluid, not only for the Wassermann reaction but as to cell count, protein estimation and colloidal gold test is extremely important in suspicious cases.

In the *Widal reaction* for typhoid fever, a positive result is of no value if the patient has received anti-typhoid vaccination within several years previously. The positive result simply means that the patient's body has a sufficient antibodies to cause an agglutination of the typhoid bacilli when brought into contact with the same. In a true case of typhoid fever with no previous vaccination, a positive Widal is rarely obtained before 10-14 days. The diagnosis of typhoid fever in the first week or ten days depends upon a positive culture of the typhoid bacilli from the blood.

The *Schick test* shows whether or not the patient has sufficient antitoxin to overcome the diphtheria toxins. If a reaction occurs, it means that the patient is susceptible to diphtheria, and would likely contract the disease if exposed to same; if there is no reaction, the patient has an immunity to the disease and for all purposes is safe against contracting same. Practically this test is being used now in many public schools, and those showing positive reactions are given the toxin-antitoxin immunizing treatment.

The purpose of this paper will have been fulfilled if in any manner the interpretation of laboratory reports has been made clearer and an estimate placed upon those of most practical value to the general practitioner.

The past decade has been one of the laboratory and its associates and during this time, frequently, too much stress has been laid upon the value of the same as diagnostic and prognostic aid. At present the pendulum is on the turn and starting on its backward swing; however, let the laboratory continue in its good work, not as the supreme criterion and monarch, but as a valuable adjunct to that most judicious and helpful ruler, clinical observation and common-sense judgment.

DISCUSSION

Dr. D. T. Babcock, Miami:

I am sure Dr. Jones does not leave me much to say—just a few points worth mentioning.

In cases of latent syphilis, we might say, the positive Wassermann test is probably one of the most valuable. Another thing that has come to our attention recently in South Florida, is the leukopenia that we see in dengue. Recently we had several cases which were very mild, and it was only after blood count was done that we were able to clear it up. You always get a leukopenia in dengue.

Another thing that might be mentioned in the important laboratory tests—the test for amœba. It is very important in cases of anemia and cases where there is a destruction of red blood cells. There is usually urolilin present in the urine. Another thing seen in gross examination of urine sometimes, especially if the number of amoeba is large, and that is a cloud or sediment which does not mean anything grossly, which is generally phosphates because the urine is so heavy with calcium salts.

When doing this test the tube should be heated up to about body temperature before inserting, and if you will also try to get some of the mucous membrane as well as the feces, you can generally locate the amoeba, as they are in the colon itself

and it is very hard to get them unless you do get some of the mucous membrane.

I am sure the main point in this paper was that we should use the laboratory as an aid to diagnosis and not rely too much on it.

Dr. B. L. Arms, Jacksonville:

I was very much pleased to hear Dr. Jones' paper, and I heartily agree with him in what he gave as the keynote of his paper—that the laboratory was to assist the physician and not to take the place of the clinical diagnosis. A negative laboratory report should certainly be weighed, and only as much value given to it as any other negative report. If a laboratory report does not agree with the clinical, the chances are that your clinical is right, and that there is something wrong with the laboratory. I don't mean that it is the fault of the technique, or anything of the kind, but something wrong with the specimen the way it was taken or handled somewhere in passage between the patient and the laboratory.

I was very glad to hear this paper and have tried to emphasize that side of it, that the laboratory was to help and not to make the diagnosis.

Dr. W. W. Kirk, Jacksonville:

It is not by way of commenting on the particular technique or the value of the tests in Dr. Jones' paper that I wish to speak, but I wish to more or less sound a keynote on a very vital side issue of laboratory work.

We all know that, particularly in the South, the charity or semi-charity patient has more extensive laboratory work done for him, and more routine work done for him and more special work done for him than any other type of patient.

In other words, the question I am bringing up in the last moments of this meeting is the vital question of how much he is going to have to pay for adequate laboratory study, which is a very vital issue with a number of people. I think that any patient who is sick enough to be in bed or in the hospital should have a reasonable amount of laboratory work done. If done along the proper lines it is a very valuable thing. In certain cases leave out certain special tests on one man which would be done for another patient, and in that way a great deal more will be accomplished for the patient, both as to health and as to his ultimate discharge from the hospital and speedy return to work.

It is very common knowledge that to have any extensive laboratory work done will mean fifteen to thirty or forty dollars, which a great number of people cannot afford to pay.

I think that the sooner the general practitioner, the internist and any man who has to have laboratory work done for his patients, will come to the conclusion that it might be the privilege of the laboratory man to examine the history and notes on the case, and, if necessary, question the patient, not with the idea of taking up the therapy of the case, but with the idea of eliminating useless examinations for that particular case, the sooner a field for a consulting pathologist could be opened that would be of value all the way around.

STRICTURE OF ESOPHAGUS DUE TO LYE BURNS*

JOSEPH HALTON, M.D.,
Sarasota, Florida.

Lye as purchased in the open market is composed of ninety-four per cent sodium hydroxide, a most destructive corrosive. The swallowing of a thimbleful is sufficient to cause a stricture of the esophagus.

I submit for your inspection two cans of lye purchased in the open market to show you how the dangers of this mixture are covered up by the insignificant display of the word "Poison" upon the label. It certainly does seem that the commercial interests should be compelled to make a more blatant display of the word "Poison" on these cans.

The cause of stricture of this sort lies primarily in gross carelessness. Lye in solution is left within easy reach of small children, whose childish inquisitiveness results in the drinking thereof.

The swallowing of lye is immediately followed by excessive flow of saliva, wretching and vomiting of the child, plus great excitement in the community.

The esophagus is a senseless kind of organ. Deficient in nerves and liable to throw spasmodic fits. This illustrates another one of nature's physicologic actions in that it protects the stomach most, the victim vomiting rather promptly, thus flushing the esophagus with antidote, acid secretion. The acid secretion of the stomach

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*Read before the Fifty-third Annual Meeting of the Florida Medical Association, held at St. Petersburg, May 19-20, 1925.

protecting this organ from the corrosive action of caustic alkali.

Immediate treatment: Give acid to neutralize the corrosive action of the alkali. One of the handiest things in all homes is a solution of vinegar. There is no marked difference for some time in swallowing, after the primary burns have healed. The stricture does not form immediately and may take several weeks. But there is a slow progressive increase, until suddenly, several weeks afterwards, almost complete esophageal stenosis occurs.

SUMMARY.

History of swallowing lye:

Deysphagia, reguritation, swallowing and later sluffing of the mucous membrane, and formation of sicatricial tissue; which contracts and results in various degrees of stenosis; loss of weight; esophagitis due to stagnation and fermentation of food in the esophagus.

Haste in dilating stricture of esophagus after injection of this corrosive fluid is to be deprecated from fear of perforation.

CASE HISTORY.

The two cases that I have to show you today are interesting from the standpoint that one refused operation and died, and the other case accepted operation and is now living.

First Case.—The child was aged three years and I saw her in consultation immediately after the burning. The child was crying and an excessive flow of saliva was pouring from its mouth. Examination did not show any blanching or discoloration inside the mouth. Six months afterwards the child was brought to the hospital and I found the following conditions on X-ray examination.

Second Case.—Was a colored child two years old, who drank lye and six months later was brought to the hospital. Her inability to swallow was pronounced and she was greatly emaciated and dehydrated.

The pre-operative X-ray picture shows:

Operation.—Under ether the abdomen was opened through the left rectus muscle. The stomach was drawn into the wound and four rows of purse string sutures inserted; stomach incised, tube introduced and the stomach wall invaginated between the purse string sutures. The X-ray picture shows tube in place.

Treatment.—Early treatment of these cases must be with water as the children are tremendously dehydrated. A person can go forty days without food but cannot well survive three days without water.

First two days two ounces of water every thirty minutes to which was added sodium bicarbonate until child's urine became alkaline, thereby offsetting starvation acidosis. Urinalysis showed 100 per cent total acidity.

First week, two ounces of milk every two hours; second week, three ounces of milk every four hours; orange juice twice per day.

Post-operative.—After three weeks' post-operative I began dilating the esophagus with catheters and bougies. (X-ray picture post-operative.)

While this treatment is not approved by the men who have had more experience in these cases than I, yet owing to the sociological condition, for instance lack of funds, one is compelled oftimes to violate the rules laid down by our well-equipped surgical centers.

Therefore to any criticism made along the line of technique and conduct of these cases, must be answered in the words appearing upon the old sign boards in the western dance hall of '49, "Don't shoot the fiddler, he's doing his best."

DISCUSSION

Dr. Walters, Ocala:

About two months ago a little girl was brought to me with a history of having swallowed lye approximately ten months previously. The girl was four years old. She was not emaciated and with the history of the duration of time it was really surprising the well-nourished condition of the child, especially after I had found a stricture which was so small that the only thing I was able to pass was an ordinary Bangs bougie. Since that time the little girl has been able to swallow fairly well, but I have never been able to get anything by this point (demonstrating) larger than an ordinary bougie. I have tried to pass a silk thread on that child hoping later to be able to use a Sippy dilator with the thread as a guide. However, I would be afraid to pass anything other than something so flexible that there would be no chance of perforating the esophagus. If this cannot be accomplished, I see no other alternative but a gastrostomy.

Unfortunately, I have been unable to see this case for three weeks, but after she had had the bougie passed once or twice her father told me that she was able to swallow, and I am pleased

that she is able to get by with enough food to maintain nutrition. You will notice quite a bit of dilatation above the stricture at this time (demonstrating).

Dr. Knauer, Jacksonville:

I think the subject of lye stricture is one of importance and should be presented yearly before the medical association. There is one thing I wish to emphasize and that is the treatment: Begin early on these cases if you are going to get any results. I have begun dilatation of these lye cases as early as the tenth or twelfth day with a great deal of success, and had very little remaining stricture. If the esophagoscopists could get these cases within the first three weeks and dilate under direct light, the majority of them would not have to have a gastrostomy performed. In the beginning, I usually dilate every day or every other day until the stricture will admit soft food, and then gradually taper down to about once or twice a week, and then once or twice a month until the patient is able to go without further dilatations.

THE PROPOSED REVISION OF THE CONSTITUTION AND BY-LAWS OF THE FLORIDA MEDICAL ASSOCIATION

A special committee consisting of three members, namely: Dr. John S. Helms of Tampa, Chairman; Dr. R. H. McGinnis of Jacksonville, and Dr. H. J. Walters of Ocala, was appointed by the Chair during the general meeting of the Association held on the 19th of May, 1925, at St. Petersburg, for the purpose of considering the feasibility of revising the Constitution and By-laws of the Florida Medical Association. The following day this committee submitted the following proposed revision of the Constitution and By-laws. This was duly read and received by the general meeting of the Association.

Article 10 of the present Constitution provides as follows: "The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at that annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been sent officially to each component county society at least two months before the session at which final action is to be taken."

Chapter 13 of the By-laws provides as follows: "These By-laws may be amended at any annual session by a majority vote of all the delegates present at that session, after the amendment has laid upon the table for one day."

It is requested that each of the integral county medical societies give due consideration to the suggested revision of the Constitution and By-laws and instruct their delegates as to their desire in accepting or rejecting the proposed changes.

CONSTITUTION

ARTICLE I.

Name.—The name and title of the corporation shall be The Florida State Medical Association.

ARTICLE II.

Purpose.—The purposes of this Association are to promote the science and art of medicine, and the protection of public health. More especially the purpose of this organization shall be to federate and bring into one compact organization the entire medical profession of the State of Florida, and to unite with similar organizations in other states to form the American Medical Association. Its purposes shall be to extend medical knowledge; to elevate the standard of medical education; to encourage enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; to safeguard and foster their material interests; and to enlighten and direct public opinion to the great problems of state medicine; so that the profession shall become more capable and honorable within itself, and more useful to the public in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III.

Section 1. *Component Societies.*—Component societies shall be those county medical societies which hold charters from this Association.

Sec. 2. The terms, county medical society and component county medical society shall be deemed to include all county medical societies now in affiliation with this Association, or which

may hereafter be organized and chartered by the House of Delegates of the Association.

ARTICLE IV.

Section 1. *Composition of the Association.*—This Association shall consist of members and delegates.

Sec. 2. *Members.*—The members of this Association shall be the members of the component county medical societies who have been certified to the headquarters of this Association, and whose dues and assessments for the current year have been received by the Executive Secretary.

Sec. 3. *Delegates.*—Delegates shall be those elected in accordance with this Constitution and By-laws to represent the component county societies in the House of Delegates of this Association.

ARTICLE V.

House of Delegates.—The House of Delegates shall be the legislative body of the Association, and shall consist (1) of delegates elected by the component county societies, and (2) the officers of the Association enumerated in Section 1 of Article VII.

ARTICLE VI.

Section 1. *Annual Session.*—The Association shall hold an annual session during which there shall be at least two general meetings, open to all registered members, delegates and guests.

Sec. 2. *Place of Meeting.*—The time and place for holding each annual session shall be fixed by the House of Delegates, or such authority may be delegated to the Council.

Sec. 3. *Special Meetings.*—Special meetings of either the Association or the House of Delegates may be called by a two-thirds vote of the Council or upon petition by twenty delegates.

ARTICLE VII.

Section 1. *Officers.*—The officers of this Association shall be a President, a Vice-President, the Past President, a Treasurer and ten Councilors.

Sec. 2. The elective officers and councilors as defined in the preceding section, shall constitute the Council and shall be the board of trustees of this corporation. The Council shall have full authority and power of the House of Delegates between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and By-Laws.

Sec. 3. *Election—Eligibility.*—The officers of this Association shall be elected by the House of Delegates on the second day of the annual session. No person shall be eligible to an elective office who has not been a member of this Association during the preceding two years, and who is not a fellow of the American Medical Association.

Sec. 4. *Term of Office.*—The President shall serve one year. The Treasurer shall be elected for a term of three years. The term of office of Councilors shall be two years, five to be elected each year. All of these officers shall serve until their successors are elected and qualified.

Sec. 5. For the purpose of membership, the fiscal year of this Association shall begin on January 1 and end on December 31. Annual dues in the State Association shall be payable in advance.

ARTICLE VIII.

Section 1. *The Scientific Assembly.*—The Scientific Assembly of the Florida State Medical Association shall be the convocation of its members for the presentation and discussion of subjects pertaining to the science and art of medicine in its widest application.

ARTICLE IX.

Seal.—The Association shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE X.

Referendum.—At any general meeting of the Association it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates, and the House of Delegates may, by a vote of its members, submit any such question to the membership of the Association for its vote. For a final vote there shall be required a majority of all the members of the Association to determine the question.

ARTICLE XI.

Amendments.—The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates and officers registered at that annual session, provided that such amendment shall have been published in THE JOURNAL of the Association two months before the annual session, and that it shall have been sent officially by the Executive Secretary to each component county society at least two months before the annual session at which final action is to be taken.

BY-LAWS

Chapter I.

Section 1. All members of this Association shall have the right to attend all meetings and to take part in all of the scientific proceedings of the annual session.

Sec. 2. *Qualification.*—The name of a physician upon the properly certified roster of this Association shall be prima facie evidence of his right to register at the annual session.

Sec. 3. *Disability.*—No person who is under sentence of suspension or expulsion from any component society of this Association, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Association.

Sec. 4. *Members.*—This Association shall consist of one class of members. Members to be eligible to this Association shall be citizens of the United States and members of component county medical societies, including all of their classifications of local membership, whose dues and assessments in the State Association have been received from the secretary-treasurer of county societies by the headquarters of the State Association.

Sec. 5. *Dues.*—If any local society provides for a diversified classification of its members, dues for them in the State Association shall be collected and transmitted to the Executive Secretary of this Association or appropriated from the funds of the local society. Exempted from this provision are such local members as are still serving as hospital interns on full time on a nominal salary, and such as have retired from active practice of medicine.

Sec. 6. *Registration.*—Each member in attendance at the annual session shall register, when his right to membership has been verified by reference to the records of this Association. No member or delegate shall take part in any of the proceedings of the annual session, nor be entitled to any of the privileges or benefits of membership until he has complied with the provisions of this chapter.

Chapter II.

Section 1. The Scientific Assembly shall hold its meetings at such time as the Council shall direct. No meeting of the Scientific Assembly shall be allowed to conflict with a general meeting.

Sec. 2. *Title of Papers.*—No paper shall be presented before the Scientific Assembly unless the title and an abstract which shall contain not less than thirty nor more than one hundred and fifty words is in the hands of the program committee at least sixty days before the first day of the annual session.

Chapter III.

Section 1. *General Meetings—President's Address—Orations.*—The general meetings shall be open to all registered members and guests. Before them at such time and place as may have been arranged shall be delivered the annual address of the President, and the annual orations.

Sec. 2. *Time Limit of Papers.*—No address or paper before this Association except those of the President, and orators, shall occupy more than twenty minutes in its delivery. No member, except by unanimous consent, shall speak more than once in the discussion of any paper nor longer than five minutes.

Sec. 3. *Papers.*—All papers read before this Association shall be its property. Each paper shall be deposited with the Executive Secretary when read. Authors shall not cause papers read before this Association to be published as original elsewhere, nor until after they have been published in the official journal of this Association.

Chapter IV.

Section 1. *House of Delegates.*—The House of Delegates shall meet annually at the time and place of the annual session of this Association.

Sec. 2. *Ratio of Representation.*—Each component county society shall be entitled to one delegate and corresponding alternate in the House of Delegates for each twenty full paid members in this Association, or major fraction thereof; provided, however, that each county society shall be entitled to at least one delegate and one alternate.

Sec. 3. *Quorum.*—A majority of the registered delegates and officers shall constitute a quorum. All of the meetings of the House of Delegates shall be open to members of the Association.

Sec. 4. *Committees of the House of Delegates.*—From among members of the House of Delegates the President for the purpose of expediting proceedings, shall appoint Reference Committees as follows: On Annual Reports, on President's Address, on Resolutions, to which shall be referred all resolutions introduced into the

House; a Committee on Credentials; tellers, sergeants at arms, and other committees considered by him to be necessary.

Sec. 5. *Funds.*—The House of Delegates shall provide funds for the expenses of the Association by a per capita assessment upon each of the county societies.

Sec. 6. *Expenses.*—The House of Delegates shall annually approve a budget of expense submitted to it by the Council.

Sec. 7. *Delegates to American Medical Association.*—The House of Delegates shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-laws of that body.

Sec. 8. *Charters.*—The House of Delegates shall, upon application to and recommendation by the Council, provide and issue charters to county societies organized to conform to this Constitution and By-laws. Such charters shall be signed by the President and Executive Secretary. The House of Delegates shall have authority to revoke the charter of any component society whose actions are in conflict with this Constitution and By-laws.

Sec. 9. *Multiple Socicties.*—The House of Delegates shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district or other classes of societies, and these societies, when organized and chartered, shall be entitled to all the privileges and representation provided herein for county societies.

Sec. 10. *Councilor Districts.*—The House of Delegates shall divide the counties of the state into ten Councilor Districts. A District society may be organized in any of these districts to meet at such a time or times as the society may fix between the annual sessions of the State Association.

The presidents of the county societies in each district shall be the vice-presidents of such district societies.

Sec. 11. *Special Committees.*—Any member who is in good standing in the Association may be appointed to serve on any committee created for a special purpose. All members of committees who are not members of the House of Delegates shall have the right to present their reports, in person, to the House of Delegates, and to participate in the debate thereon, but shall not have the right to vote.

Chapter V.

Section 1. *Committee on Nominations.*—The House of Delegates on the first day of the annual session shall elect a committee on nominations consisting of ten delegates, one from each councilor district. The committee on nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of three members for the office of President, and of one member for each of the other office to be filled at that annual session. No two candidates for President shall be from the same district, and each candidate for Councilor must be a resident of the district for which he is nominated.

Sec. 2. *Nominations.*—The report of the nominating committee and the election of officers shall be the first order of business of the House of Delegates at the second meeting of the House.

Sec. 3. *Election of Officers.*—All elections of officers shall be by ballot and a majority of the votes cast shall be necessary to elect except for delegates and alternates to the American Medical Association. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected. In case no delegates or alternates for the American Medical Association receive on the first ballot a majority of the vote, the nominees shall be declared elected in the order of the highest number of votes received, until the allotted number shall have been chosen. In case of a tie vote for delegate or alternate, the tie shall be determined by lot.

Sec. 4. *Nominations From Floor.*—Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

Chapter VI.

Section 1. *Duties of President.*—The President shall preside at the meetings of the Association and of the House of Delegates. He shall appoint by and with the consent of the Council, a committee of three from the Council, on Auditing and Appropriations, and a committee on Arrangements for the annual session. Each of these committees shall serve for a term of one year. He shall appoint all committees for the selection of which other provision is not made. He shall

deliver an annual address at such time, during the annual session, as may be arranged. He shall give a deciding vote in case of a tie. He shall be the chairman of the Council, and shall perform such other duties as parliamentary usage may require. He shall be a member of the Council for a period of one year immediately succeeding his term of office. He shall be ex-officio a member of all committees of the Association.

Expense of President.—The necessary traveling expenses incurred by the President in the line of duty herein imposed may be allowed by the Auditing and Appropriations committee, but this shall not include his expenses in connection with the annual session of this Association.

Sec. 2. *Vice-President.*—The Vice-President shall be a member of the Council, and shall act as President in the absence or disability of the President. If the office of President should become vacant the Vice-President shall succeed to the presidency.

Sec. 3. *Treasurer.*—The Treasurer shall give bond, at the expense of the Association, in such an amount as shall be required by the Council. He shall be the financial agent of the Association. He shall receive all funds due the Association from every source whatever, except accounts due THE JOURNAL in the conduct of its business. He shall deposit the funds in a bank of deposit in the name of the Florida State Medical Association. He shall keep a complete set of books concerning the receipts and expenditures of the Association, except those of THE JOURNAL. He shall, under direction of the House of Delegates, sell or lease any estate belonging to the Association and execute the necessary papers. He shall pay money out of the treasury upon voucher as directed by the Auditing and Appropriations committee, (Chapter VII, Section 5), and shall render a monthly trial balance of his accounts to the chairman of the Auditing and Appropriations committee and to each member of the Council.

Sec. 4. *Executive Secretary.*—The Executive Secretary shall be ex-officio the secretary of the Association and all its committees. He shall be the executive agent of the Association transacting its business under the direction of the officers of the Association. He shall collect all dues from members of the Association through the secretaries of the component societies, and pay them to the Treasurer. He shall be the business manager and news editor of THE JOURNAL. He shall pay over the profits of THE JOURNAL at the end of each fiscal year, or whenever ordered to do so by the Auditing and Appropriations committee or by the House of Delegates. Whenever the income of THE JOURNAL does not meet its expense, he shall make requisition, which must be approved by the Auditing and Appropriations committee, on the Treasurer for the necessary amount. He shall have charge of the business offices of the Association and may employ such aid as shall be authorized by Council. He shall be custodian of all record books and papers belonging to the Association, except those of the Treasurer. He shall provide for the registration of the members and delegates to the annual session. He shall provide for the reporting of the proceedings of the several sessions. He shall conduct the official correspondence notifying members of meetings, officers of their election, committees of their appointment and duties, and shall perform such other duties as may be assigned to him by the Council. He shall give bond, at the expense of the Association, in such amount as shall be required by Council.

CHAPTER VII.

Section 1. *Council Meetings.*—The Council shall hold daily meetings during the annual session of the Association, and at such other times as necessity may require, subject to the call of the President or on petition of three Councilors. It shall meet on the last day of the annual session of the Association for re-organization. At this meeting it shall elect a secretary who shall keep a permanent record of its proceedings. It shall cause to be published in THE JOURNAL of the Association, a record of its meetings and actions.

Sec. 2. *Duties, Individual.*—Each Councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once each year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members, and to keep in touch with activities of and aid in the betterment of the various societies.

Sec. 3. *Expenses of Councilors.*—The necessary traveling expenses incurred by each Councilor in the line of duties herein imposed may be allowed by the committee on Auditing and Appropriations, but this shall not include his expenses in attending the annual session of the Association.

Sec. 4. *Duties, Collective.*—The Council shall be the executive body of the House of Delegates and shall, between sessions, exercise the powers conferred on the House of Delegates by this Constitution and By-laws.

The Council shall be the board of censors of the Association. It shall consider all questions involving the right and standing of members, whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or of a county society. Its decision in all cases, including questions regarding right of membership in this Association, shall be final, except that an appeal may be made to the House of Delegates.

Sec. 5. *Auditing and Appropriations Committee.*—The President shall appoint three members of the Council, a committee on Auditing and Appropriations, as provided in Chapter VI, Section 1 of these By-laws. The duties of this committee shall be: To prescribe the method of accounting and to audit any or all accounts of the Florida State Medical Association. The committee shall prepare and present to the Council for action at its first meeting in January of each year, a budget providing for the necessary expenses of the Association. Any surplus or balance of funds for the year shall go into the general fund for re-apportionment.

Sec. 6. *Committee on Arrangements.*—The Committee on Arrangements for the Annual Meeting shall consist of three members of Council to be appointed by the President, as provided in Chapter VI, Section 1 of these By-laws, at least six months in advance of the annual session. On recommendation of this committee, the Council shall appoint a general chairman of a local auxiliary committee on arrangements, who, together with the president of the local county medical society, shall appoint and organize the personnel from among the members of the society in the county in which the annual meeting is to be held. The auxiliary committee shall, through the committees of its own selection, provide suitable meeting places and shall have general charge of all local arrangements subject to the approval of the Committee on Arrangements and Council. All receipts accruing from the annual session shall be turned over to the Committee on Arrangements, and all expenditures in connection with the annual session must be authorized in advance by the Committee on Auditing and Appropriations. Immediately following the annual session, the Committee on Arrangements shall forward to the Treasurer of the State Association any accumulated balance. It shall meet any deficit by application to the Council, through the Committee on Auditing and Appropriations.

Sec. 7. *Vacancies.*—The Council shall by appointment fill any vacancy in office occurring in the interval between the annual sessions of the House of Delegates. The appointee shall serve until his successor has been elected and qualified.

Sec. 8. *Program.*—The Council shall determine the character and scope of the scientific proceedings of the Association for each session. At least thirty days previous to each annual session, it shall prepare and issue a program, announcing the order in which papers, discussions and business of the House of Delegates shall be presented. This program shall be adhered to by the Association as nearly as practicable.

Sec. 9. *Executive Secretary.*—The Council shall employ an Executive Secretary, who need not be a physician, nor a member of the Association.

Sec. 10. *Salaries.*—The salaries of all employes of the Association shall be fixed by Council.

Sec. 11. *Headquarters.*—The Council shall provide such state headquarters for the Association as may be required to properly conduct its business.

Chapter VIII.

Section 1. *Standing Committees.*—The Standing Committees of the Association shall be:

1. A Committee on Public Policy and Legislation.
2. A Committee on Publication.
3. A Committee on Medical Education and Hospitals.
4. A Committee on Medical Economics.

Each of these committees shall consist of three members, each of whom shall serve for a term of three years. One member of each of these committees shall be appointed annually by the President, by and with the consent of the House of Delegates, provided that at the 1926 annual session one member of each of the foregoing committees shall be appointed for a term of three years; one each for two years, and one each for one year.

Sec. 2. *Public Policy and Legislation.*—The Committee on Public Policy and Legislation shall consist of three members, one of whom shall be appointed each year, and the President and the Vice-President. This committee shall meet annually, or as may be necessary. This committee shall represent the Association in securing and enforcing legislation in the interest of public health and of scientific medicine.

Sec. 3. *Publication.*—The Committee on Publication shall consist of three members, one of whom shall be appointed each year. The Committee shall have referred to it all reports on scientific subjects, and all scientific papers and discussions heard before the Association. It shall be empowered to curtail, abstract or reject papers and discussions. The committee shall have authority to arrange for the publication and distribution of THE JOURNAL.

Sec. 4. *Medical Education and Hospitals.*—The Committee on Medical Education and Hospitals shall consist of three members, one of whom shall be appointed each year. This committee shall serve in this state for the Council on Medical Education and Hospitals of the American Medical Association, on behalf of the Florida State Medical Association, and shall have referred to it all questions pertaining to hospitals and medical education.

Sec. 5. *Medical Economics.*—The Committee on Medical Economics shall consist of three members, one of which shall be appointed each year. It shall investigate all matters affecting the economic status of physicians and shall report annually to the House of Delegates such recommendations as may, in its judgment, seem proper.

Sec. 6. *Reports.*—Reports of the standing and special committees shall be published in the official journal of the month preceding the date of the annual session of this Association, and these reports must be in the hands of the Executive Secretary sixty days in advance of the annual session.

CHAPTER IX.

Section 1. *Assessments.*—The annual dues and assessments shall be determined by the House of Delegates, and shall be levied per capita on the members of the Association. They shall be payable on or before January 1st of the year for which they are levied. The secretary of each component society shall cause to be collected and shall forward to the officers of the Association the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership.

Sec. 2. *Receipts of Dues—Qualifying Membership.*—The record of payment of dues and assessments on file in the offices of the Association shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Association and of the House of Delegates.

Sec. 3. *Penalty for Failure to Remit.*—Any county society which fails to make the reports required, at least thirty days before the annual session of the State Association, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Association or of the House of Delegates.

CHAPTER X.

Ethics.—The ethical principles governing the members of the American Medical Association shall govern members of this Association.

CHAPTER XI.

The deliberations of this Association shall be conducted in accordance with parliamentary usage as defined in Roberts' Rules of Order.

CHAPTER XII.

Section 1. *County Societies.*—All county societies now in affiliation with the State Association or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and By-Laws shall, upon application to the House of Delegates, receive charters from this Association, provided that their Constitution and By-Laws shall have been submitted to the Council and received its approval.

Sec. 2. Only one component medical society shall be chartered in each county.

Sec. 3. *Qualifications.*—Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Association. Every reputable and legally qualified physician who does not practice, nor profess to practice sectarian medicine, and who is not affiliated with any organization which aims to foster an exclusive dogma in therapeutics, and who is a bona fide resident of the same county, shall be eligible for election to membership.

A member of a component society whose license has been revoked shall be dropped from

membership automatically as of the date of revocation. The Council of the State Association shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council.

Where it is more convenient for a member to attend the meetings of the component county society in an adjoining county, upon request of the society in the county of his residence, his membership may be transferred and accredited to said adjoining county society.

Sec. 4. *Appeals.*—Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him, shall have the right to appeal to the Council. A county society shall at all times be permitted to appeal or refer questions involving membership to the Council of the State Association for final determination.

Sec. 5. In hearing appeals the Council may admit oral or written evidence as in its judgment will most fairly present the facts, but in the case of every appeal both as a board and as individuals, the Councilors shall, preceding all such hearings, make efforts at conciliation and compromise.

Sec. 6. *Removals.*—When a member in good standing in a component county society moves to another county in this state, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he removes, such member shall be considered to be in good standing in the county society from which he was certified and in the State Association to the end of the period (respectively) for which his dues have been paid.

Sec. 7. *Functions and Duties.*—Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

Sec. 8. *Certification of Delegates.*—At some meeting in advance of the annual session of this Association, each component county society shall elect delegates and individual alternates therefor to represent it in the House of Delegates of this Association, in accordance with Chapter IV, Section 2 of these By-Laws. The secretary of each county society shall send a list of such delegates and alternates to the Executive Secretary of this Association at least thirty days before the annual session. Representatives in the House of Delegates shall be contingent on compliance with the foregoing provisions.

Sec. 9. *Roster of Members.*—The Secretary of each county society shall keep a roster of its members, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each county meeting to his district Councilor and to the Executive Secretary.

Chapter XIII.

Section 1. *Amendments.*—These By-Laws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been published in The Journal two months before the annual session.

Sec. 2. *Repeal.*—Upon the adoption of this Constitution and these By-Laws, all previous Constitutions and By-Laws are thereby repealed.

All of which is respectfully submitted.

JOHN S. HELMS,
Chairman Executive Committee.

FIFTY-THIRD ANNUAL MEETING OF
THE FLORIDA MEDICAL ASSSOCIATION
WILL BE HELD AT
GAINESVILLE, MAY 3rd, 4th and 5th

The Journal of the Florida Medical Association

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EDITOR
SHALER RICHARDSON, M.D.

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THE GAINESVILLE MEETING

Gainesville is planning an elaborate reception for the members of the Florida Medical Association. The local committee for months past has been diligently planning to make the Fifty-fourth Annual meeting the most successful. The intellectual capital of the state is a site befitting the rendering of such a program as is being prepared by the Scientific Program Committees. An opportunity to know our State University will be afforded during our stay in Gainesville and will materially assist in a close cooperation between our association and the State University. Let us acquaint ourselves with our University during our visit to Gainesville.

Every facility for comfortably housing the members of the Association is assured.

Printed in this issue is an article by Dr. Murphree, President of the University, which within itself should stimulate attendance.

INCREASE IN THE ANNUAL ASSOCIATION DUES

Attention of the members of the Florida Medical Association is called to the following proceedings of the House of Delegates of the Association at their last meeting. The following is extracted from the proceedings as recorded by the official stenographer and appearing in the Journal of the Florida Medical Association, Volume 11, Nos. 9, 10, 11 and 12, June, 1925.

FIFTY-THIRD ANNUAL MEETING, GAINESVILLE, MAY 3, 4, and 5

Page 220, May 19, 1925: "Motion by Dr. Henson that the By-Laws providing for annual dues, which now reads: 'Shall be $5.00 per annum,' be amended to read: 'Shall be $10.00 per annum.'"

"In accordance with the provisions of the By-Laws, the proposed amendment was laid upon the table until the following day."

Page 221, May 20, 1925: "Motion to amend the By-Laws, and thereby raise the annual dues from $5.00 to $10.00 was seconded and carried."

The increased cost of the publication of THE JOURNAL and the necessity of employing a Business Manager for the Association has made the increase in dues imperative. The Executive Committee in the Annual Report made by Dr. John S. Helms as Chairman, at our last Annual Meeting, strongly advocated the increase in dues and it was following this that the House of Delegates voted to make the change.

Many State organizations are employing lay-secretaries with success. Ohio and Wisconsin have profited greatly by such a measure. With the growth of THE JOURNAL and the Association it is impossible for a busy practitioner to conduct the business affairs of our organization.

The Erie County Medical Society of Pennsylvania has undertaken a rather unique means of preventing as nearly as possible the promiscuous calling of their members for unnecessary night work. Our County Medical Societies would probably profit by adopting a similar method. The following letter has been forwarded to each of their members:

ERIE COUNTY MEDICAL SOCIETY

Dear Doctor:

Do you like to have your patients call you in the evening and on Sunday and holiday afternoons when they could just as well have called you earlier? Or do you like to have these hours to yourself?

There is only one way to get people out of the habit of eternally spoiling your evenings and Sundays and that is by charging them more. The Erie County Medical Society proposes to make it easy for you to get people into better habits.

The inclosed slips embody the sense of the resolution adopted unanimously at the January meeting. We suggest that you put one of these slips into each bill you send out and that you carry a few in your bag to leave with people who call you in the evening or afternoons or Sundays and holidays.

The Society is also putting a large "ad" in all the Erie papers, both English and foreign press, to run once a week for six weeks covering this subject. By these means, your patients will readily see that it is nothing personal upon your part when you charge the extra fee, and we are sure that by earnest cooperation on your part that in a few months you will be making most of these calls in the day time and the luxury of the evening and Sunday afternoons will be yours.

Extra slips furnished on request.

Erie County Medical Society.

Attached to the letter is the following notice to patients:

PHYSICIANS' NOTICE TO THE PUBLIC

If in need of a physician, call him if possible between the hours of 7 a. m. and 6 p. m.

Upon Sundays and holidays, try to put your calls in during the morning hours.

Calls after 6 p. m. on week days and on the afternoons of Sundays and holidays, such as Christmas, New Year, Decoration Day, July 4th, Labor Day and Thanksgiving Day are 1/3 higher. Calls from 11 p. m. until 7 a. m. are 2/3 higher.

Erie County Medical Society.

Dr. C. Eugene Riggs, professor emeritus of Neuro-Psychiatry, University of Minnesota, read a paper entitled "The Dynamics of Personality" before the Duval County Medical Society at their last monthly meeting.

STATE NEWS ITEMS

Doctor and Mrs. H. Mason Smith of Tampa are being congratulated on the arrival of a fine son.

Dr. C. C. Coleman of Richmond, Virginia, was a recent visitor in Jacksonville.

Gov. John W. Martin has appointed Dr. S. E. Driskell of Jacksonville a member of the State Board of Medical Examiners.

The Dade County Medical Society recently voted to raise their annual dues to $50.00.

The members of the Association are deeply grieved to learn of the death of Dr. J. Harry Walters of Ocala. Dr. Walters was very active in State Medicine and a beloved physician in his community.

Dr. J. Lee Kirby-Smith of Jacksonville expects to spend several months in European clinics.

Jacksonville is assured another modern and up-to-date hospital. It is understood that five hundred thousand dollars is to be expended in the erection of a new plant for St. Vincent's Hospital. Hospital facilities in Jacksonville and Florida are far from commensurate with the population. The building of new hospitals is welcomed by the medical profession.

ADVERTISING NOTES

NEW SILVER COMPOUNDS — The silver salts have lost none of their prestige, notwithstanding the flood of topical antiseptics and germicides which is overflowing the market. On the other hand, certain improvements are being made with the object of avoiding the irritating or staining feature of the older silver compounds.

By an ingenious combination of silver iodide with a gelatinous protein, this salt has been made impervious to the action of sunlight, so that its solutions (or suspensions) do not turn dark on exposure. Thus the staining effect of the silver is avoided. And it would appear from bacteriologic tests made by the manufacturers (tests which, of course, any bacteriologist can repeat) that the germicidal activity of the new silver preparation is at least equal to that of pure carbolic acid; moreover, that, whatever the concentration of the solution, inflamed tissues are not irritated by its application.

The name of the product referred to is Neo-Silvol, and the manufacturers are Parke, Davis & Co. Some of the applications of Neo-Silvol are mentioned in an advertisement which appears in this issue.

RESEARCH RESULTS.—Recent research in the field of medicinal chemistry, coupled with scientific physiological and clinical investigation, is effecting profound changes in the practice of medicine.

Discoveries have already been announced which are changing the methods of treating diabetes, high blood pressure, and syphilis. So promising is the research work now being carried on in universities, and by large pharmaceutical manufacturers, that further important discoveries may soon be expected. It is not too much to hope that definite discoveries may even be made in the field of cancer and tuberculosis

During the past year, announcement of t discovery of several new and important medicinal chemicals has been made by the Research Department of the Abbott Laboratories, North Chicago, Ill. Among these discoveries are Butesin Picrate, a new chemical body, combining both anesthetic and antiseptic properties.

Other important research results from the Abbott Laboratories are Butyn and Ben Fumarate, both of which are fully described "New and Non-Official Remedies."

During the past ten years the following important Council-Passed medicinal chemicals have been manufactured by, and added to the list of the Abbott Laboratories: Anesthesin, Acriflavine, Barbital, Chlorazene, Dichloramine-T, Cinchophen, Neocinchophen, Neutral Acriflavine, and Procaine.

These notable additions to the list of American-made, medicinal chemicals promise much for the future cordial relations between scientific, manufacturing chemistry and progressive medical practice.

THE GROWING IMPORTANCE OF GELATINE IN INFANT FEEDING.—Some time ago, Dr. Joseph Leidy, of Philadelphia, said: "The combination of gelatine and milk in infant feeding was long used by my father and the late Dr. W. Pepper. I have continued to use it during the past thirty years, and am of the opinion that it gives results when many other combinations fail."

In recent months the growing interest of the medical profession in gelatine has been noticeable. Doctors are reporting gratifying successes in preventing such infant ailments as milk colic, regurgitation, vomiting, diarrhœa, excessive gas formation and constipation by 1% addition of gelatine to the milk diet.

Thomas B. Downey, Ph. D., Fellow of the Mellon Institute, Pittsburgh, has, by standard feeding tests, determined that the addition of pure, plain unflavored gelatine increases the nourishment obtainable from milk by about 23%.

In discussing the digestibility of milks, especially by infants and young children, Alexander and Bullowa have pointed out that the protein content may not be considered as a unity because it is composed of two proteins, casein and lactoalbumin, with entirely dissimilar properties. Casein is an irreversible colloid exceedingly susceptible to coagulation by acid and rennin, while

ctoalbumin is reversible and serves to protect e former.

Analysis shows that mother's milk contains a igh proportion of lactoalbumin, the casein be- ng adequately protected. Mother's milk is re- sistant to coagulation by acids and rennin and its greater acceptability as the food for the in- fant is reflected by the low mortality where the young are breast-fed. On the contrary, cow's lk contains a high proportion of casein and atively little lactoalbumin; it is poorly pro- tected. In consequence, the casein of cow's milk is very susceptible to coagulation by acids and rennin. The mere coagulation of the casein is not the whole story, because the coagulum car- ries down much of the fat present, yielding masses that have a tendency to cohere and are of a texture that is quite resistant to penetration by the digestive juices. The voiding of such masses occurs too frequently in artificial feed- ing; nutrients are lost to the organism and it is quite probable that decomposition products of an undesirable nature are formed within these undigested curds.

This is in no way a reflection on the great utritive value of cow's milk which is indispen- sible but simply emphasizes the deterrent con- dition it meets in the human stomach which must be neutralized to insure the complete assimila- tion of the milk nutriment.

From this viewpoint an obvious modification in artificial feeding is the protection of the un- stable casein by the addition of suitable protec- tive colloids.

It is of interest to give careful attention to gelatine in this place. As previously mentioned, its colloidal protection is of the highest order. It is also an excellent emulsifying agent and may function as such in either an acid or an alkaline medium. It is a common product of exceptional purity, and is an easily digested protein which is readily combined with milk. In combination with milk, the protein content is increased, food value is increased, volume is not appreciably increased and digestibility is increased. Theo- retically the employment of gelatine in the child dietary is sound, and laboratory experimentation and clinical experience substantiate these con- clusions.

The approved method of combining gelatine with milk is as follows:

Soak, for ten minutes, one level tablespoon- ful of pure, unflavored, unsweetened gelatine (Knox) in one-half cup of cold milk taken from the baby's formula; cover while soaking; then place the cup in boiling water, stirring until gelatine is fully dissolved; and add this dis- solved gelatine to the quart of cold milk or the regular formula.

It must be remembered that there is a great difference in gelatine. Realizing the importance of absolute purity in any gelatine that is com- bined in milk or used in any way in the dietary, the laboratories of the Charles B. Knox Gelatine Company maintain a strict and constant control of the production of Knox Sparkling Gelatine. No sweetening, artificial flavor, or coloring, is ever added to this product.

ABSTRACT DEPARTMENT

SURGERY

The Use of Diathermy and of the Quartz Lamp for Conserving the Temperature of the Viscera and Promoting the Welfare of the Patient Before and After Abdominal Operations Crile G. W. Surgery, Gynecology and Obstetrics, 1926, XLII, 218.

The trend of the best surgical thought for the past few years has been along lines of Physiology, and the preservation of normal physiological processes in the various organs and systems, during and after surgical procedures, in order to still further lower surgical mortality, and to make surgical intervention less and less of an ordeal for the human body to undergo. It is therefore interesting and advantageous to us to summarize some recent work done at the Cleveland Clinic and published in the paper referred to above.

Upon the proven grounds that the liver is essential to life; that the metabolic and chemical functions of this essential organ are dependent for their successful consumation upon the maintainance of certain degrees of temperature in this organ; that these processes are decreased 10% for each degree of lowering of the liver temperature; and that the liver temperature is lowered from exposure of the abdominal viscera, in proportion to the amount and time of the exposure, Crile and his associates have made use of the physical power of Diathermy to maintain and to increase the temperature of the liver during and after operations upon this organ and its accessories, and in other abdominal operations. The agent has also been used as an adjunct to

postoperative care of patients in the following ways:

First, to continue maintaining the temperature of the liver; second, to raise the general body temperature in shock, by passing the current from one foot through the body to the other foot; and thirdly, to maintain the normal temperature in the lungs in the prevention of pneumonia as a postoperative complication.

They feel that a good many bad risk cases are being given just that additional chance for life by this procedure which means the difference between life and death, in the cases which are hovering on the border line between the two.

J. K. S.

Diagnosis and Treatment of Fracture of the Skull as Developed in The Cincinnati General Hospital—Annals of Surgery, Feb., 1926, Vol. LXXXIII, No. 2, Pg. 182.

Carter gives in a most practical manner the experience at the Cincinnati General Hospital in the handling of 223 cases of fracture of the skull. Omitting the discussion of pathology in these injuries he enters directly upon the problem from the point of view of the physician who is confronted with a patient suffering from a fractured skull. He does discuss the importance of the state of consciousness, the pulse, the temperature, the respiration and the neurological functions as the indicators of the severity and type of lesion. His observation of these points are of most valuable aid to the physician. With the knowledge gained from these one can usually give an accurate prognosis and can decide upon the proper line of treatment. The making of such observations constitutes what he calls the "observation period." This, he says, "is the most important phase of the treatment."

Spinal tapping Carter advocates strongly, not only as a diagnostic aid but also for its therapeutic value in selected cases. All simple fractures, except those with very mild symptoms, are subjected to spinal puncture. In the presence of moderately high pressure these are repeated until the pressure remains normal. When there is evidence of high intra-cranial tension and high spinal pressure, which is relieved only slightly or temporarily by the puncture, decompression by operation is indicated. If puncture lowers high tension and pressure without relief of the patient's general symptoms, decompression seems of no value, as the injury is one of the brain itself rather than pressure on the brain. He believes that very high intra-spinal pressure with clear fluid to be a diagnostic of extra-dural hemorrhage.

Operative treatment consists in debridement of compound fractures, craniotomy for intracranial hemorrhage, and subtemporal decompression in fractures without local symptoms, but with a high intracranial pressure. Operation has been resorted to in only 56 of the 223 cases.

It is important that we keep in mind the keynote of the paper as expressed in the last sentence: "The most important phase of the treatment is the period of observation, when one views the changing train of events, weighs the importance of each, and directs his therapy accordingly."

E. J.

DERMATOLOGY

"Bismuth Salicylate in Experimental Rabbit Syphilis. A Study of Toxicity, Absorption, Elimination and Spirocheticidal Power," O. M. Gruhzit, M.S., M.D. Archives of Dermatology and Syphilology, Feb., 1926, Vol. 13, No. 2.

In an article well illustrated with charts, roentgenograms, and photographs, the author enters into the history of the use of bismuth and its salts in the treatment of syphilis in humans and gives a clear, concise record of the use of bismuth salicylate in the treatment of syphilitic rabbits, and the various effects of the drug as observed when administered to dogs.

The summary of the work done is quoted verbatim.

SUMMARY

Absorption, elimination, toxicity and spirocheticidal power of bismuth salicylate has been studied.

The bismuth preparations are absorbed relatively slowly. Absorption of bismuth salicylate is more rapid than that of metallic bismuth suspensions, and is the same as that of potassium bismuth tartrate or sodium potassium bismuth tartrate.

From the total amount of bismuth eliminated, from 77 to 92 per cent. was found in the urine and from 23 to 8 per cent. in the feces.

The elimination reaches a maximum with single doses in about five days and in about ten days with fractional administration. Following the initial maximum elimination the rate of elimination becomes fairly uniform, but is greater with larger doses administered.

A fairly uniform rate of elimination increasing with increased dosage tends undoubtedly to avoid cumulative effect.

The toxicity of bismuth salicylate is comparatively low. A dose of 2 gm. of body weight per kilogram appears to be toxic, with severe injury to the kidneys and liver. A dose of 1 gm. per kilogram appears to be readily tolerated and only a mild degree of injury was noted to the kidneys and the liver.

A therapeutic cumulative dosage of .5, 1, 1.5 and 2 mg. per kilogram per eight to eleven injections produced no loss of weight or histologically demonstrable lesions in the kidneys and the liver of experimental rabbits.

The gain in weight of the treated rabbits with cumulative therapeutic doses was considerably more following cessation of treatment than during the period of treatment.

Albuminuria has never been found in dogs receiving 2, 8.4 and 24 mg. of bismuth salicylate per kilogram of body weight.

Blood urea nitrogen in dogs receiving a single treatment of 8.4 and 24 mg. per kilogram, respectively, and a cumulative therapeutic dose of 2 mg. per kilogram, or a total of 408 mg., remained within the normal limits.

Bismuth salicylate in 5 mg. per kilogram rendered the lesions free from spirochetes in 48 hours. A 3 mg. dose produced similar results in generalized orchitis, but not on sclerotic gumma.

A cumulative dosage of 2 mg. per kilogram rendered the lesion free following the second administration in from four to seven days.

Doses of 1 and 1.5 mg. per kilogram rendered the lesion free in seven days, and .5 mg. doses in some cases appeared equivalent to 1 mg., in other cases it took about twenty days before the spirochetes disappeared. J. L. K. S.

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